KENTUCKY BOARD OF PHARMACY
Spindletop Administration Bldg., Ste 302
2624 Research Park Drive
Lexington, KY 40511
Phone 859-246-2820 Fax 859-246-2823

Permit No. _____
Date Issued _____
(FOR OFFICE USE ONLY)

Application for License to Operate as a Drug Wholesaler or Manufacturer

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer'. Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires September 30th following the date of issuance.

1. Name of Facility _____

Physical Address of Facility _____
(Street and Number)
City _____ State _____ County _____ Zip _____

Phone Number _____ Fax Number _____

Mailing Address of Facility _____
(Street and Number)
City _____ State _____ Zip _____

Check and complete one of the following and attach proper fee:

☐ New Wholesaler $100.00
Proposed date of Opening _____
(Filed with Board 30 days in advance of Opening)

☐ New Manufacturer* $100.00
Proposed date of Opening _____
(Filed with Board 30 days in advance of Opening)
***[Manufacturer license is issued to resident facilities only.]**

☐ Change of Ownership $75.00
Date of Proposed Acquisition _____
Name of Previous Owner(s) _____
(Confirmation statement of previous owner must be attached)

☐ Change of Address/Location $75.00
Date of Proposed Relocation _____
Previous Address _____

☐ Name Change $5.00
Previous Name _____

Registration Numbers and Expiration Dates:

DEA: _____ Exp. Date: _____/_____/_____
FDA: _____ Exp. Date: _____/_____/_____
CHFS: _____ Exp. Date: _____/_____/_____
(KY Controlled Substances License)

2. Name and title of facility contact person:

Name: _____ Extension: _____

3. **Has applicant, or any officer, agent or employee of the applicant, ever been convicted of any federal and/or state drug or controlled substances violation?**

☐ Yes, attach explanation ☐ No

4. **Schedule of Hours:**

Monday . . . . _____ A.M. to _____ P.M.
Tuesday . . . _____ A.M. to _____ P.M.
Wednesday ._____ A.M. to _____ P.M.
Thursday . . . _____ A.M. to _____ P.M.
Friday . . . _____ A.M. to _____ P.M.
Saturday . _____ A.M. to _____ P.M.
Sunday . . ._____ A.M. to _____ P.M.

5. If operations include drug manufacturing, identify the Pharmacist-in-Charge:

Name: _____ License No:_____

6. Ownership:

Individual Partnership Corporation LLC Other

Name, title and address of owner(s)/partners/corporate officers, attach separate sheet if needed.

_____

_____

The Board may refuse to issue or renew a permit, or suspend, temporarily suspend, revoke, fine or reasonably restrict any permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit. KRS 315.121.

I hereby certify that the foregoing is true and correct to the best of my knowledge. If the registration herein applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

_____ _____/_____/_____

(Signature of Owner/Officer and Title) *(Date)*

Copies of your resident state permit and last inspection report, if applicable, must be enclosed.